Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISHAL KAPUR, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-3396-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The requestor provided designated doctor services 3/16/11 by determining maximum medical improvement (MMI) and impairment (IR) then billed Texas Mutual $650.00 for this with one unit of code 99456-W5… Texas Mutual paid the requestor $650.00 for this MMI exam. (Attachment 1). 2. The requestor submitted an amended bill to Texas Mutual on 4/07/10. This bill has a different billed amount for code 99456-W5 and the number of units was changed to 4. Texas Mutual reviewed this amended bill then reimbursed the requestor an additional two units at $300.00 for IR of the eye and brain concussion. (Attachment 2) No further payment is due because only three areas of impairment were documented, not four."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2011	99456-W5-WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated April 18, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

   Explanation of benefits dated May 06, 2011
   - CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

   Explanation of benefits dated May 27, 2011
   - 193 – ORIIGNAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - 790 – THIS CHARGE WAS REIMBURSED AFTER RECONSIDERATION

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor original submitted a billing for the DD examination Maximum Medical Improvement/Impairment Rating (MMI/IR) services for 1 body area/unit in box 24G of the CMS-1500 for $650.00 and billed with CPT code 99456-W5-WP. This amount was paid prior to MFDR. After this payment, the requestor amended their billing and added 3 additional body areas/units for a total of $1,100.00 for CPT code 99456-W5-WP. The respondent re-audited the billing and allowed an additional $300.00 making the pre MFDR reimbursement $950.00. Review of the documentation supports that MMI was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The right elbow as well as contusions of head, face, and eyes the four areas claimed as rated. Documentation supports a Range of Motion (ROM) IR method on the right elbow (upper extremities) for a MAR of $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). Documentation also supports the IRs per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the three non musculoskeletal conditions of head, face, and eye contusions per 28 Texas Administrative Code §134.204 (j)(4)(D)(iv) and (v) which each have a MAR of $150.00 x 3 = $450.00. The combined MAR for the MMI and the 4 units rated for the IR areas is $1,100.00.
2. The respondent has already reimbursed the amount of $950.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is entitled to additional reimbursement of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the additional amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		February 09, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.